

Part 1

Second Edition, Revised, Enlarged.

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ILLUSTRATED



MEDICINE AND SURGERY

EDITED BY

GEORGE HENRY FOX,

Professor of Diseases of the Skin,
College of Physicians and Surgeons, New York,

AND

FREDERIC R. STURGIS,

Professor of Venereal and Genito-Urinary Diseases,
Post-Graduate Medical School of New York,

WITH THE CO-OPERATION OF

SPECIALISTS IN THE VARIOUS DEPARTMENTS OF MEDICINE AND SURGERY.

CONTENTS:

EXTRA-UTERINE PREGNANCY;—TREATMENT BY ELECTRICITY, *One Illustration.*
By A. D. ROCKWELL, A.M., M.D., Formerly Prof. of Electro-Therapeutics
in New York Post-Graduate Medical School and Hospital.

ACROMEGALY-PARALYSIS AGITANS, - - - - - *Two Illustrations.*
By SIMON BARUCH, M.D., Physician to Manhattan General Hospital.

REMOVAL OF THE ARM, THE SCAPULA, AND PART OF THE CLAVICLE FOR
OSTEO SARCOMA OF THE SHOULDER, - - - *Three Illustrations.*
By J. S. WRIGHT, M.D., Prof. Operative Surgery, Long Island College Hospital,
Brooklyn.

ELASTIC OPERATIONS FOR CURE OF ALLEGED CANCER, - - - *One Illustration.*
By A. C. POST, M.D., Emeritus Prof. Surgery, University City of New York.

NEW YORK:

E. B. TREAT, No. 5 COOPER UNION.

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Assisted by a corps of Eminent Physicians and Specialists in the various departments of medicine.

THE DESIGN of this work is to faithfully represent many of the rare and specially interesting surgical and pathological cases, including methods of treatment and the latest discoveries in surgical appliances, such as have hitherto been imperfectly understood, or lost for lack of suitable means of reproduction. By means of photographs from life, chromo-lithographs, designs from nature by special artists, and engravings, of the highest artistic excellence, much valuable and instructive material is brought within the reach of the Profession, which has heretofore been inaccessible.

This publication stands alone. It has no competitor; it trenches on no other, was needed, and because needed is published. It is not the hobby of any one physician, or set of physicians, or their specialties; neither is it run by any college clique or medical faction. Its contributions are select and cosmopolitan, its mechanical execution surpassed, and its eminently practical value is vouched for by the able corps of editors and contributors in the various departments of Medicine and Surgery.

THE TEXT is entirely original and made thoroughly practical by the most approved methods of illustrating produced at great expense expressly for this work. Those from photographic negatives are by the Artotype process, in printing ink, and will not fade, by the well-known artist, E. Bierstadt, of New York. When found necessary to emphasize pathological effects, careful hand-coloring has been introduced. The special drawings from nature, and of surgical operations, are by the anatomical artists Wright, Kohler, Tiers, J. Gaertner (late from the General Hospital, Vienna), and others, and the same are reproduced in from seven to ten printings by chromo-lithograph under the direction of Frank Jones, widely known to the profession as the government artist under Surgeon-General Barnes in publishing the Medical and Surgical History of the War.

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"This new candidate for professional favor is a model of its sort, containing elegantly illustrated articles of eminent professors. The general make-up is in the form and on the plan of the photographic illustrations of skin diseases, which proved itself so deservedly popular with the profession."—*New York Medical Record*.

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E. B. TREAT, Publisher, 5 Cooper Union, New York.

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CLINICAL PROFESSOR OF DISEASES OF THE SKIN, COLLEGE OF PHYSICIANS AND SURGEONS, NEW YORK.

AND

FREDERIC R. STURGIS,

PROFESSOR OF VENEREAL DISEASES, MEDICAL DEPARTMENT UNIVERSITY OF THE CITY OF NEW YORK.

WITH THE CO-OPERATION OF

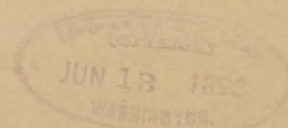
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SECOND EDITION: REVISED, ENLARGED.

NEW YORK:

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PREFACE.

THE aim of the "Illustrated Medicine and Surgery" has been to secure in permanent form the publication of interesting and instructive matter, which would be of little value without suitable illustrations, and which has heretofore been withheld from the profession or published only at personal expense.

The flattering notices of the Medical Press, and a large and increasing subscription list would seem to indicate that a measure of success has already been achieved.

The Editors would thank the profession for their kindly support of a new and difficult undertaking.

GEORGE HENRY FOX.

FREDERIC R. STURGIS.

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THE TREATMENT OF EXTRA-UTERINE PREGNANCY BY ELECTRICITY.

BY A. D. ROCKWELL, A.M., M.D.,

Formerly Professor of Electro-Therapeutics in the New York Post-Graduate Medical School and Hospital and Electro-Therapeutist to the Woman's Hospital in the State of New York, etc.

IF detected before the third month, tubal pregnancy can be treated not only with perfect success by electricity, but with little if any pain to the mother, or subsequent ill result or discomfort.

The diagram illustrates fairly well the position of the electrodes, and a few words will sufficiently explain the practical details of the method.

The internal electrode (F) consists of a metal bulb attached to an insulated stem and connected with the negative pole of the battery. This is carried up to that portion of the tube where the foetus (C) is developing through either the rectum or vagina, according to the position and size of the tumor. Any ordinary flat sponge electrode, three or four inches in diameter, will answer for external application; and this is to be placed upon the abdomen (G) directly over the foetal mass. Both currents—the galvanic and faradic—have been successfully used to destroy the foetal life; but an experience in the treatment of some sixteen cases of this character convinces me that the galvanic current is greatly to be preferred. Space will not permit me to give fully the grounds for this preference, but they are based upon both theoretical and practical considerations. The galvanic current is more certain in its effects than the faradic, because it produces mechanical effects in equal degree with the latter, while its physical, chemical, and physiological effects are far greater.

In destroying the foetal life all these properties are called into play, and in hastening the subsequent process of absorption they are especially important.

If the galvanic current is used, the interruptions may vary in rapidity from twenty-five to one hundred to the minute. There is, indeed, no rule as to this.

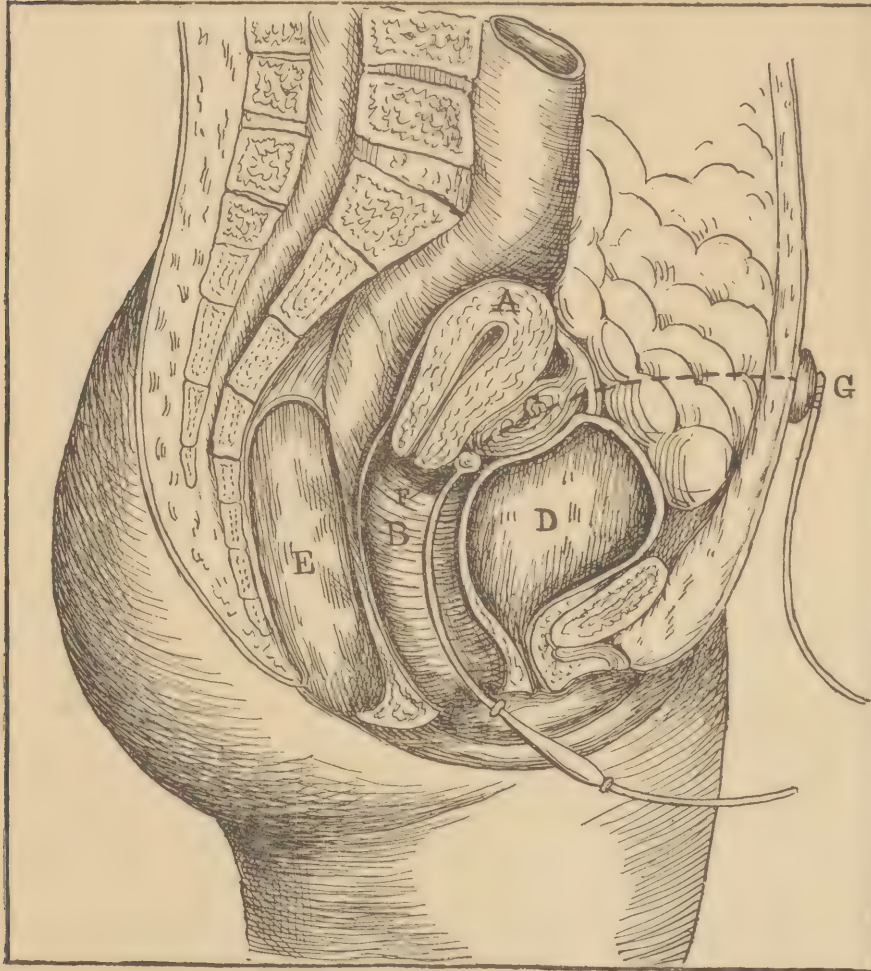
We are in great measure to be governed by the susceptibility of the patient, and we should see to it that the strength of the current is not so great as to cause violent muscular contractions. A seance of five to ten minutes, with interval of rest, is in all probability sufficient to destroy the foetal life; but as it is impossible at the time to positively determine this fact, it is, perhaps, safer to repeat the applications on two or three successive days.

If the case under observation has been diagnosed correctly and is truly one of tubal pregnancy, the destruction of the foetus will be followed in a very short time by an appreciable diminution of the tumor, and ultimately by complete disappearance.

It is possible that a small cystic tumor might at first be mistaken for an extra-uterine pregnancy, but it is incredible that any such misapprehension should remain after an intelligent use of electricity.

THE TREATMENT OF EXTRA-UTERINE PREGNANCY BY ELECTRICITY.

No form of tumor, cystic or otherwise, would decrease in size with any such rapidity, if at all, as do these tubal enlargements after the destruction of the foetal life by interrupted currents of electricity. Cases of extra-uterine pregnancy that are far advanced—say to the fourth month—must be treated



with the greatest care if electricity is used ; and in these cases it would perhaps be as well to rely wholly on the knife. The tube becomes, of course, greatly distended, and an injudicious application of either form of current might result in rupture. In cases of this kind, however, there is one method of application that has in my hands proved effective and is attended with no danger. Reference is made to applications in which the galvanic current is rapidly increased and as rapidly decreased without interruptions.

The following case affords a valuable illustration of this method of procedure. I was called some years ago to see in consultation a young un-

married woman with this history: Two weeks previously she began to suffer much pain in the right side, together with very slight irregular discharges of blood.

The patient had confessed to the possibility of pregnancy, and examination elicited many of the objective and subjective signs of this condition. Nausea occurred every morning, and changes had taken place in the areola.

Digital examination revealed the fact that the os uteri was little changed from its normal condition. By pressure over the right side it was possible to feel a certain hardness not present on the other side, but by conjoined manipulation with one finger in the vagina a distinct rounded mass could be felt. Examination per rectum revealed its presence even more distinctly. If pregnancy existed—and of this there seemed to be no reasonable doubt—it had advanced nearly to the fourth month, and

THE TREATMENT OF EXTRA-UTERINE PREGNANCY BY ELECTRICITY.

as the tumor was large—much larger than in any case previously seen and treated by the electrical method—there was evidently no time to lose. I immediately treated this patient by introducing one pole into the rectum, and placing the other externally.

On account of the great distension of the Fallopian tube, and the danger of rupture, I felt the necessity of exercising the utmost care, and consequently made use of the interruptions with a current strength of but twelve cells, representing an electro-motive force of about sixteen volts. No milliamperimeter being at hand, it is impossible to give the exact measurement of current strength. The current would then be quickly increased without interruptions and allowed for a few moments to pass in a continuous stream until the patient could no longer bear the burning pain of the external electrode, and then as quickly decreased. The treatment was concluded by a second application on the following day. Visiting the patient some two weeks subsequently, I found that the tumor had decreased in size at least one half, and in the course of a few months was hardly discernible. The use of electricity in the treatment of extra-uterine pregnancy is a most important advance in electro-therapeutics, and is a procedure that is entirely American in its inception.

Were accidents of gestation of this kind an every-day affair, instead of comparative infrequency, the discovery of the great value of electricity in their treatment might well be considered one of the most important of recent therapeutic measures. It is unfortunately true that there are many who still deery the method and advocate the use of the knife in those early discovered cases in which electricity is indicated.

They cannot deny that if detected before the third month electricity is capable of destroying the foetal life without pain or danger to the mother. But, they say, a foreign body is left, therefore the knife should be used; and this in the face of proofs innumerable that no possible harm results from the contents of the foetal sac, which becomes encysted and quickly absorbed.

Two assertions are often made by the opponents of the electric method of treatment: First, that it is almost impossible to detect the condition before the third month, and that many supposed cases of extra-uterine pregnancy are not cases of pregnancy at all; second, that electricity is by no means sure to destroy the foetal life. In reply to the first of these I have this much to say: a patient comes to you with a cessation of menstruation of two or three months' standing, associated with paroxysms of pain, with or without a slight show of blood. On examination you distinctly feel a slight enlargement along the line of the Fallopian tube. It may or may not be a case of tubal gestation, but you treat it with electricity, and the pain immediately ceases and the tumor quickly disappears. What could it have been? Certainly not an ordinary cyst or solid tumor, for these do not disappear in this way. The only rational conclusion is that it was an ectopic gestation—the only possible condition that would thus readily resolve itself under this method of electrical treatment. In regard to the second objection, the difficulty has been perhaps that the faradic current is too often used to the exclusion of the galvanic. It is a great mistake to rely exclusively on the faradic current, since it is far more inefficient in its destructive properties than is the galvanic. It possesses in equal degree neither the physical, chemic, nor physiologic effect of the galvanic current, while mechanical effects are common to both currents. The galvanic current always kills. In all the many cases of extra-uterine pregnancy that have come under the personal observation and treatment of the writer, the galvanic current was exclusively used, and always with success.

ACROMEGALY—PARALYSIS AGITANS.

BY SIMON BARUCH, M.D.,

Physician to the Manhattan General Hospital, Juvenile Asylum, and Montefiore Home for Chronic Invalids, New York.

ACROMEGALY.

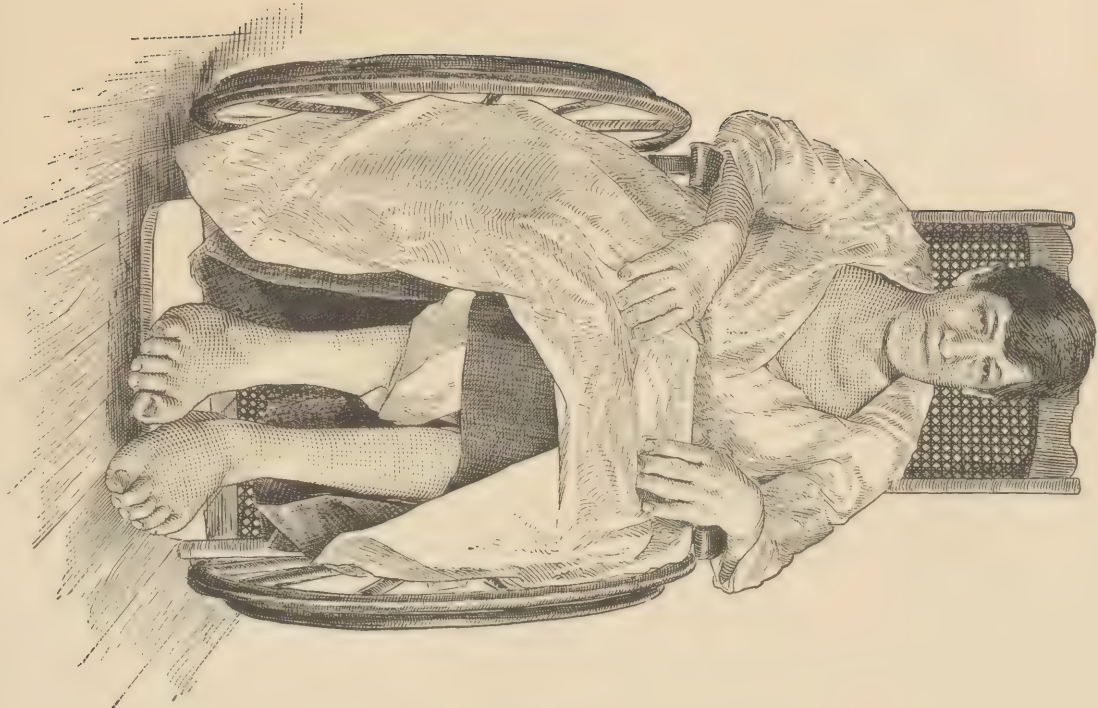
THIRTY-FIVE cases only of this singular affection having been published, its rarity warrants the brief history and illustration of a classical case in these pages, in order that they may serve as aids in diagnosis.

A. H., æt. 36, of good family history, was in good health until nine years ago. Menstruation began at 15 and ceased at 18. She married at 20. Shortly afterward she noticed that her feet were sometimes swollen. One of her fingers increased so much that she was compelled to remove a ring from it. Three years later she noticed an elongation of the lower jaw beyond the upper. At the same time her friends noticed a general increase of her size.

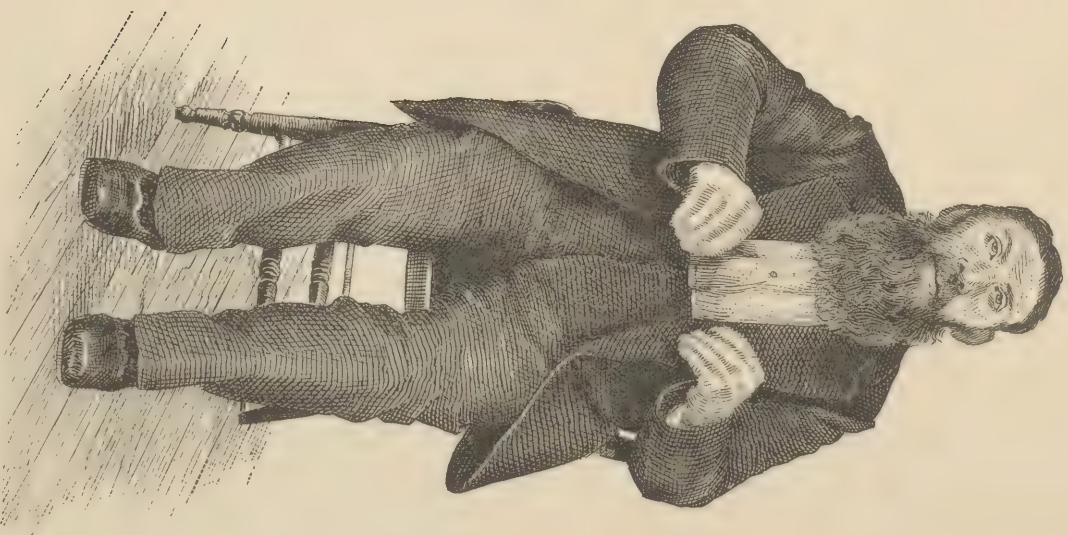
After a wagon-ride she suffered pains in back and extremities, and could not walk well. These pains have continued during the past six years, especially in the head, which prevented her doing any work, or reading.

Status præsens. There is an enlargement of the head, hands, and feet. All the facial and cranial bones are thickened; the line of the lower teeth extends beyond the upper; the lower jaw is much enlarged. The tongue is hypertrophied, the skin over the face is thickened and has an œdematous appearance. She cannot keep her head erect—assumes a kyphotic position. The chest is greatly enlarged, due to thickening and enlargement of the sternum, clavicular, and costal, as shown in the drawing. All the bones of the hands and feet are enlarged in every direction. The long bones also are somewhat increased and thickened, chiefly at the epiphysis. The muscles are atrophied from inactivity. The pelvis is enlarged and scoliotic. Pressure upon the enlarged bones is painful. Patient very anæmic: complains of headache, vertigo, anorexia.

She has not grown larger during her two and a half years' residence at the Montefiore Home; her general condition has improved, headaches have ceased, pains diminished; she is more intelligent, and passes her time in reading and needlework. As Virchow, Marie, Fraentzel and others have noticed, there is no dulness on percussion over the region of the thyroid gland in this case. The great prominence of the lower portion of the occipital bone referred to as a novel manifestation by Schultze, had been previously noticed in this case in the able and most complete account published in the *New*



ACROMEGALY.
[Case Dr. Simon Baruch.]



PARALYSIS AGITANS.
[Case Dr. Simon Baruch.]

ACROMEGALY—PARALYSIS AGITANS.

Yorker Medicinische Monatschrift, May, 1889, by Dr. I. Adler. A reference to this excellent paper will amply repay perusal.

The salient features of the case are so well represented by the artist, that it is equivalent to standing in its presence.

PARALYSIS AGITANS.

M. B., æt. 65, merchant, German, has a sister suffering from the same malady. No other nervous diseases in the family. He did not walk until four years of age. Was once cured of intermittent fever, by a fortune-teller, after all other remedies failed; had typhoid fever in 1876. At the age of 55 a friend called his attention to the peculiar position in which he held his left arm. He then noticed twitching of the middle toes of the left foot; one year later tremor in left leg, under excitement.

The extremities are so contracted that they can be approximated only with difficulty. Knee jerk is prevented by contraction of the joint. Tremor and contractions are more marked on the left side. He complains of pain and burning sensations in the extremities, often preventing sleep; cannot stand long in one position; must be fed on account of tremor of hands.

The drawing illustrates graphically the peculiar attitude of these patients, and thus furnishes a valuable aid to diagnosis. For the history of these cases I am indebted to Dr. Max Rosenthal, late Senior Resident of the Montefiore Home for Chronic Invalids.

THE REMOVAL OF THE ARM, THE SCAPULA, AND PART OF THE CLAVICLE FOR OSTEO-SARCOMA OF THE SHOULDER.

READ BEFORE THE BROOKLYN SURGICAL SOCIETY, NOVEMBER, 1891.

BY J. S. WIGHT, M.D.,

Professor of Operative and Clinical Surgery at the Long Island College Hospital, Brooklyn, N. Y.

THERE are some leading questions in the case which may be considered under the following heads: 1. The injury, which was the antecedent of the disease; 2. The disease, which was the reason for the operation; 3. The operation, which was performed for the relief of the patient; 4. The medical treatment, which supplemented the operation.

1. The injury: J. B., an engineer, age thirty-six, in October, 1890, was putting up a machinery belt, when his left arm caught and was violently pulled forward and upward, causing a serious injury of the left shoulder, which was more or less paralyzed at the outset, and remained in this condition. The doctor he consulted made an unsuccessful effort to put the shoulder back into joint, as if there had been a dislocation. Four days after the accident the patient went to work with his right hand, but his left continued useless. About a month after the accident, the patient fell down and struck upon his injured shoulder, and suffered additional pain. Still he kept at his work. The swelling, which had not subsided, increased subsequent to the second accident. At the end of four months the upper part of the injured arm "began to grow in size." Two months before coming to the College Hospital, "it was getting quite large." This was the last week in September. There was increasing pain as the growth enlarged. During the three or four months before coming to the hospital, his weight had been reduced from 154 pounds to 133.

2. The disease: This patient came under my observation a few days before admission to the hospital. I found his left hand and forearm somewhat atrophied, and the upper part of the arm, including the bone and the soft parts, very much enlarged. The limb was worse than useless, it was in the way of the patient in the performance of his work. The disease appeared to involve the shoulder-joint to some extent. I made a diagnosis of osteo-sarcoma, and my opinion was confirmed by Drs. Burge, Lewis, Rand, Cochran, Rogers, and others. The disease was making rapid progress, and the time when any operation would be impossible was fast approaching. An operation somewhere beyond the shoulder-joint was necessary, and there was not much to hope for even then.

The disease was osteo-sarcoma, and might have come without the injury: Suppose we say that the injury was the exciting cause. The stress of the injury was on the nerves, for they suffered

THE REMOVAL OF THE ARM FOR OSTEO-SARCOMA.

most, as was evident. Are we not then to look in the direction of the nerves for the pathological change, or for its inception? If so, the first point that takes our attention is that of the influence of the nerves over the nutrition of the parts supplied by them, and we may even include in this the nutrition of the upper part of the arm-bone, which was the part primarily involved. And it does not militate against this view to say that the upper part of this bone is a favorite seat of this disease. Are we not then left with the reasonable conclusion that the pathological change came from the derangement of the nerve influence over the nutrition of the various structures involved, and that the change in the disordered nerves was brought about by the severe avulsion produced by the accident? In the past I have studied the theory of causation of this disease by means of micro-organisms; nor do I exclude this cause now, for it might be that the injury prepared the soil for their implantation and growth, an event that might not have taken place if there had been no injury to the shoulder.

3. The operation: A subscapular amputation of the shoulder, or, perhaps, it was an amputation of



OSTEO-SARCOMA OF THE SHOULDER. VIEWS AFTER THE OPERATION.

the clavicle, including the scapula. The operation was performed in an aseptic manner. In the usual way, I ligated the subclavian artery in the third part of its course. The clavicle was considerably "raised upward," and the artery was very adherent to its sheath and the connective tissue around it; the ordinary aneurism-needle was found to be incompetent to detach the artery from its bed, and so I used my artery forceps to get under the artery; nor would the jaws of the forceps open enough to seize the ligature, and so I pushed the aneurism-needle after the forceps as I removed them, and then by means of that passed the ligature. In the mean time, I put a ligature around the transversalis colli artery, not only because it came in my way, but also because this would help to control the subse-

THE REMOVAL OF THE ARM FOR OSTEO-SARCOMA.

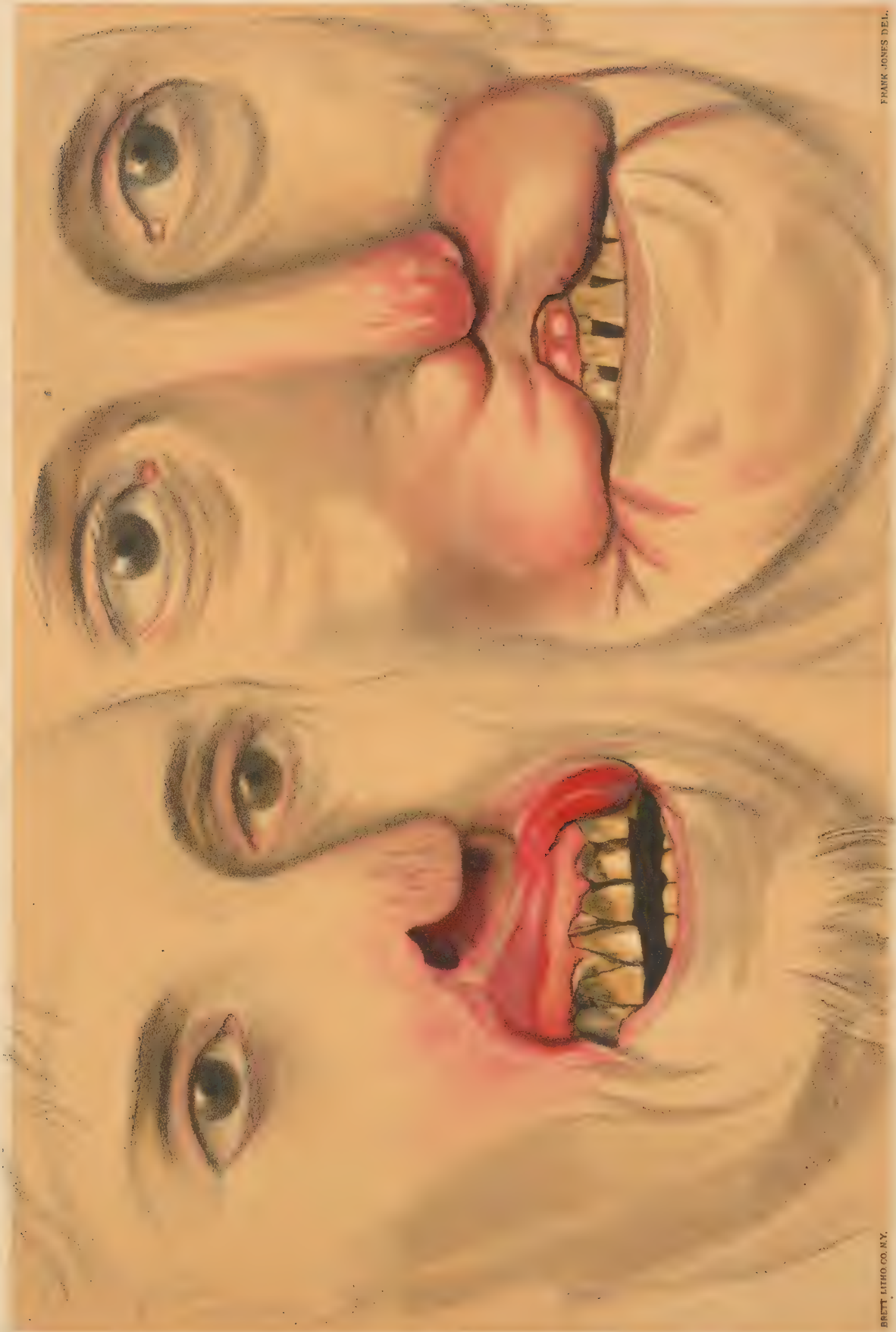
quent hemorrhage. The ligation of the subclavian was the longest and most difficult part of the operation. Then I made an incision forward some distance in front of the shoulder, say about three inches; and then another incision back of the shoulder as far as the spine of the scapula. Next the clavicle was exposed by dissection and sawed off, so as to leave about one-third of the bone attached to the sternum, the outer two-thirds being dissected up from the subclavian tissues. After that, the incision on the back of the shoulder was continued to the axilla nearly, and an incision was made obliquely downward to the apex of the scapula; the scapula, with its posterior muscles, was then completely exposed; the lower portions of the scapula were cut from its attachments, and the body of the bone, with the subscapularis, was separated from the underlying parts; finally, the trapezius was severed above and the pectoralis major in front, when the entire shoulder was cut off. There was not much hemorrhage from any portion of the wound, which was very extensive. There were some enlarged glands in what was once the axilla, or rather upon the pectoral wall of the axilla. While I was removing these enlarged glands, Drs. Rand and Cochran were busy ligating the cut ends of the various blood-vessels exposed by the operation. The flaps were sufficient to cover its entire surface. After the aseptic irrigation the flaps were stitched in place, with a drainage tube going from the anterior to the posterior surface.

During the operation, the heart action of the patient was so weak that it was not easy to detect the pulse, and this fact caused some delay in the ligation of the subclavian. Yet the patient reacted quite well in about two hours after the operation. The case did well subsequent to the operation. Some discharge came from the wound for ten or fifteen days. One small abscess formed from a retained clot; it was opened and healed in a few days. In many parts of the wound there was primary union, not only between the edges of the flaps, but also of the flaps to the underlying surface. A very small point of one of the flaps sloughed, but not enough to leave a scar of any magnitude.

4. The medical treatment: Soon after the operation, I directed my patient to have four or five grains of carbonate of lime before each meal, and one-fortieth of a grain of bromide of arsenic after each meal. You ask me the reason for this: I have found in quite a large number of cases of sarcoma, that these remedies have prevented the recurrence of the disease, when I have performed thorough operations—that is, when I have removed all the suspected tissue. It would make no difference whether the surrounding tissue were in danger of infection from micro-organisms, or from invasion by some peculiar affection of the nerves—the result is the same—that is, the disease has not recurred after an extended administration of these remedies, provided there has been a thorough operation.

I have been asked, Why did you remove the scapula? For the following reasons: 1. The scapula was involved in the infection, and must have been, with its soft parts, the seat of the peculiar nerve disturbance affecting the patient's shoulder; 2. The scapula, or any part of it, would have been in the way of successful repair; and any part of it would not be of much use; 3. The removal of part of it would have prolonged the operation, and so endangered the life of the patient; 4. As it is now, we have the entire surface one of continuity of the integument, and this is very important, for new formations are apt to recur in scars that are at all extensive.

There seems to be a little of the axillary integument left. It was the seat of some induration which arose after the operation. This induration slowly disappeared under treatment.



I. RESTORATION OF UPPER LIP
(Case of Prof. A.C. Post.)

ABSENCE OF THE UPPER LIP,

THE RESULT OF APPLICATIONS FOR CURE OF ALLEGED CANCER.

PLASTIC OPERATIONS.

BY ALFRED C. POST, M.D., LL.D.,

Emeritus Professor of Surgery in, and President of the Faculty of the Medical Department of the University of the City of New York; Visiting Surgeon to the Presbyterian Hospital, N. Y. City, &c., &c.

CASE.—Chas. Gardiner, Ireland, 65, shoemaker, married, admitted to hospital April 26th, 1880. Family and previous history good.

Twenty-six years ago, a small wart appeared on upper lip, a little to right of median line. This remained twenty-two years without increasing in size and without pain. Four years ago, applications were made to it with the intention of destroying it, but they were not effectual. The wart ulcerated and increased in size, involving nearly the whole of the upper lip, and a portion of the right ala nasi; but without giving rise to pain or constitutional disturbance. On March 31st, 1880, he went to a cancer doctress, who applied an escharotic paste which destroyed all the parts involved in the disease.

On admission, there was found to be a deficiency of nearly the whole of the upper lip, the deficiency extending from the right cheek just without the angle of the mouth to a point about twelve mm. within the left commissure of the lips. The columna nasi had entirely disappeared, and there was a deep notch at the lower part of the right ala nasi about fifteen mm. in depth. The upper gums were entirely exposed to view. The patient was unable to keep his food between his teeth, and to retain the saliva within his mouth. (See plate I, fig. 1.)

May 1st, 1880. The patient having been etherized with the usual precautions, I performed the following operation for the restoration of the lost features. (See fig. 3, 4 and 5.) I commenced by separating from the cheek the small remnant of the left extremity of the upper lip, by an incision extending through its whole breadth and thickness, leaving the flap thus separated, attached at the junction of the nose and cheek. The loose end of this flap and its anterior surface were excised, so as to leave raw surfaces for adhesion in the new position in which they were to be placed. A portion of this integument at the end of the nasal pyramid, and at the lower border of the septum

ILLUSTRATED MEDICINE AND SURGERY.

nasi were also excised, to produce raw surfaces corresponding with those of the labial flap. This flap was then drawn upward and to the right, and attached by sutures to the denuded surface of the nose, so as to form a new columna, the mucous membrane looking downward, and the denuded cutaneous surface looking upward. The position of the new columna was necessarily oblique, it being my intention to remove the obliquity by a subsequent operation, if it should be found necessary.

The jagged edge of the parts at the junction of the right cheek with the lip was then

excised so as to leave an even margin, and a flap was made from the left cheek, included between two incisions, of which the lower extended outward and a little downward from the angle of the mouth, and the upper, outward and a little upward from the junction of the ala nasi with the cheek, the flap thus formed being a little larger in all its dimensions than the left half of the space to be occupied by the new upper lip. From the outer extremity of this flap, two incisions were made in the arcs of circles whose concavities looked toward the mouth, including between them a curved pedicle for the flap, about half the width of the flap itself. A corresponding flap with a curved pedicle was cut from the right cheek, the flap being made sufficiently wide, not only to supply the right half of the upper lip, but to afford a patch to fill up the notch at the lower extremity of the right ala nasi. A horizontal incision was made twenty-two

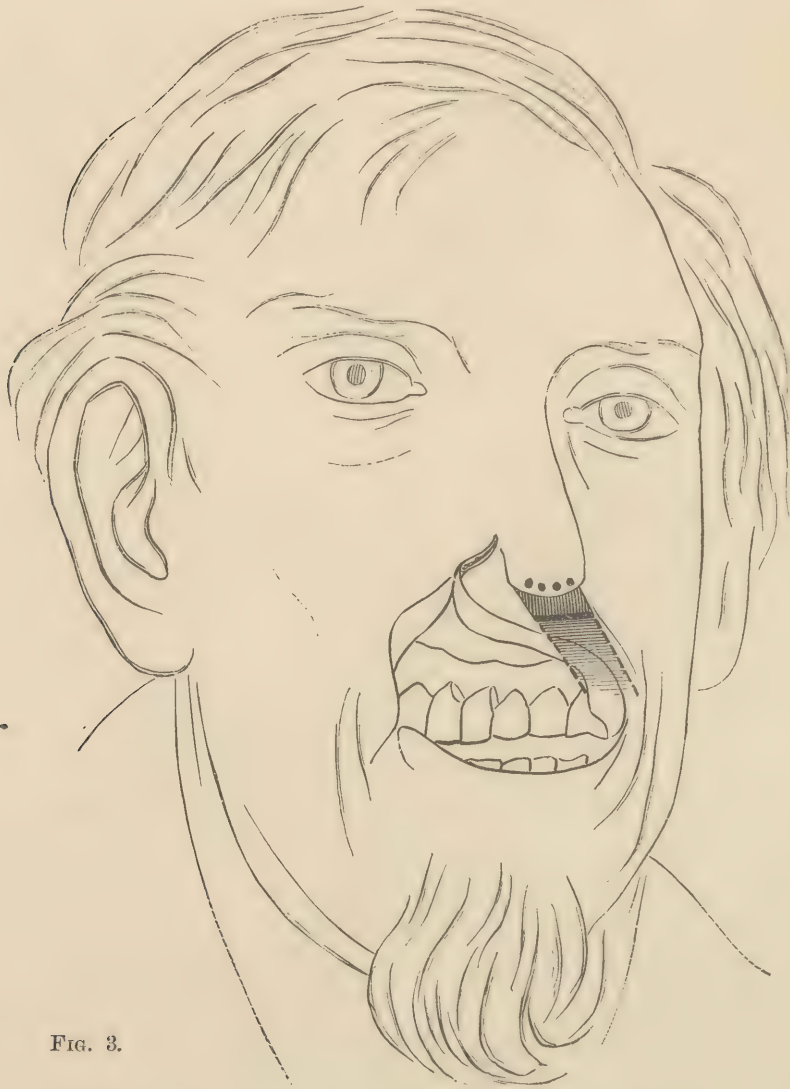


FIG. 3.

mm. in length, separating the portion of the flap designed for the reparation of the ala nasi from that which was intended for the completion of the upper lip. A thin strip was removed from the margin of the notch at the lower edge of the ala nasi, for the reception of the flap. The two flaps designed for the formation of the upper lip were then brought together in the median line, and joined by three pin sutures, and the remaining edges of the wound were united by numerous fine

ABSENCE OF THE UPPER LIP.

silken sutures. Before bringing the flaps together, as there was found to be some tension I cut across the mucous membranes of the pedicle of the right flap near its lower extremity, thinking that the mucous membrane of the flap itself would receive a sufficient vascular supply from the vessels of the submucous cellular tissue. A new vermilion border was formed for each division of the lip, by drawing the mucous membrane forward, and attaching it by sutures to the external integument.

The patient bore the operation well, being kept in a state of anæsthesia by a very moderate use of ether.

Fig. 3 exhibits the flaps which were designed to restore the columna nasi, the upper lip, and the defective portion of the right ala nasi.

Fig. 4 shows the new columna attached by sutures to the apex of the nose.

Fig. 5 exhibits the remaining flaps secured in place by sutures and the space behind the right flap, left to granulate.

May 2nd. Patient is in a comfortable condition. He has taken milk and beef-tea during the night. The wound looks well, except that the vermilion border of the right flap has a somewhat dusky appearance.

5th. One of the pins, and about half of the sutures were removed to-day. A large part of the wound has united by first intention, but the vermilion border of the right flap is evidently gangrenous.

May 10th. The remaining sutures were removed.

16th. The sloughy margin of the right flap came away to-day.

25th. Union is complete, except where the slough separated from the margin of the lip and at the posterior superior margin of the pedicle, where cicatrization is rapidly advancing.

June 22nd. Every part of the sore is healed, except a minute portion about one cm. in length, and five mm. in breadth, at the posterior and superior margin of the pedicle, where the surface is covered with a thin scab on a level with the surrounding parts. The line of union of the right flap with the adjacent parts is at its proper level, except for a space of three cm. in length, extending outward from the angle of the mouth, when the line of union is depressed, and the adjacent surface puckered.

The line of union of the left flap is level on its superior margin, and on the posterior side of its pedicle, but in other parts it is depressed, and the adjacent surface somewhat puckered. The vermilion border of the left flap is perfect throughout, and extends a little to the right of the median line. The free border of the right flap has no proper mucous covering, but the skin is inverted so as to form a fair substitute for a vermilion border, from the angle of the mouth about half way to the median line. Between the labial borders of the right and left flaps, there is a notch about two cm. long at the base, and extending upward to the height of one cm. above which the two sides of the lip are firmly but somewhat irregularly united.

The flap which fills up the notch in the right ala of the nose is firmly united, but is abnormally thick. The new columna is perfectly united with the septum and the apex of the nose, and its obliquity is much less than might have been anticipated. (See plate I, fig. 2, see fig. 9, exhibiting the result of the first operation.)

June 23rd. I performed the following supplementary operation. I first detached the left side

ILLUSTRATED MEDICINE AND SURGERY.

of the posterior extremity of the newly formed columna to the extent of about three mm. I then excised a segment from the right edge of the columna, about three mm. in breadth in the middle, and tapering toward each extremity, and brought together by fine sutures the sides of the chasm thus produced. I separated from the cheek the newly formed patch of the right ala nasi, by a deep incision, and dissected out a considerable portion of the subcutaneous adipose tissue, so as to diminish the thickness of the flap, and to reduce it to its proper level. The patch was secured in its place

by fine sutures. I then dissected out the thin cicatricial tissue on the right side of the middle of the lip, so as to leave the two divisions of the lip each with a straight parallel margin. The incisions were made in such a manner that the left or longer flap was bevelled at the expense of its mucous surface, and the right or smaller flap was bevelled at the expense of its cutaneous surface, so that when the flaps were afterwards brought together, the left flap overlapped the right one, while the cutaneous surfaces of the two flaps were on the same plane. This was done in accordance with a plan suggested by Dr. Packard of Philadelphia in a paper read before the New York Academy of Medicine. The two flaps were both detached from the bridles which bound them to the upper jaw and to the buccal mucous membrane. I then made an incision on each side on a line corresponding with the upper margin of the lip, extending into the cheek to the distance of about four cm., and the same line

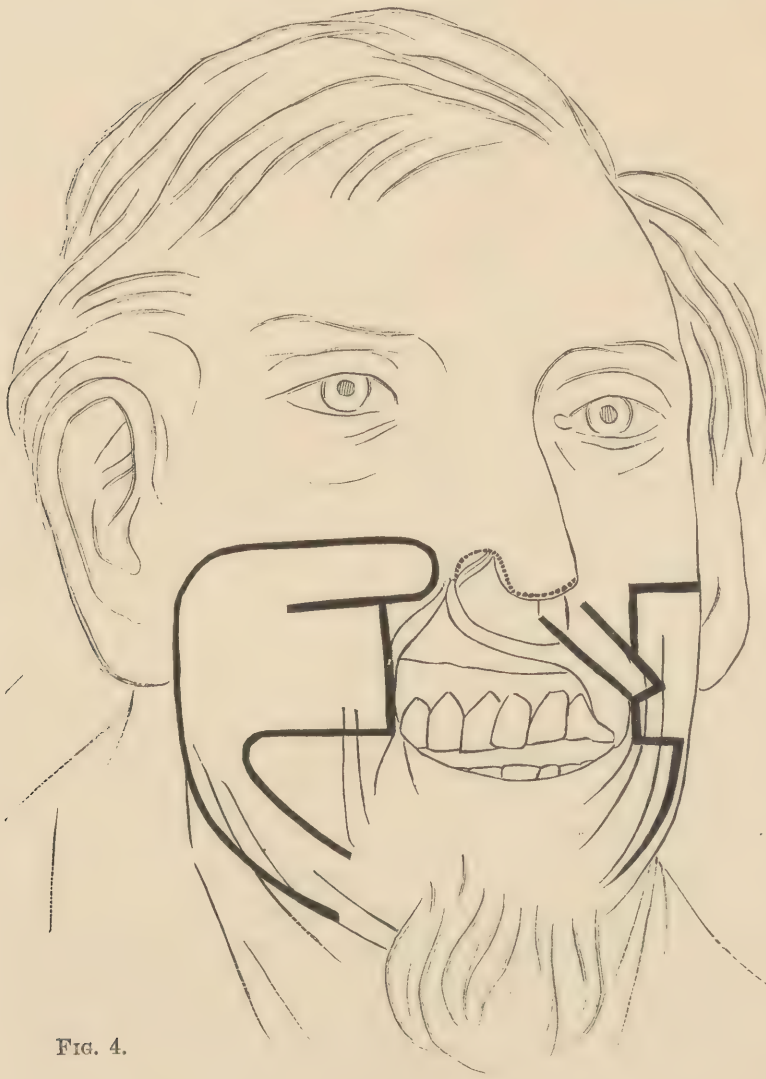


FIG. 4.

of incision was then curved downward behind the angle of the mouth, and forward along the lower lip to the extent of three cm., the flaps of the lower lip being about twelve mm. in breadth. The two flaps of the upper lip were then brought together near the median line, and were secured by two pins and a number of fine sutures. A small triangular surface on the right cheek, about twenty-five mm. in length was left to granulate. This space was lightly filled with picked lint moistened with a solution of carbolic acid, one part to forty, and the surface was

ABSENCE OF THE UPPER LIP.

covered with lint moistened with collodion. The patient bore the operation well, and was in a good condition at its close.

July 3d. There is a considerable separation of the flaps in the median line. There is sloughing of a considerable portion of right side of lip. Surface thoroughly washed with carbolic lotion.

20th. Since the separation of the sloughs, the flaps have been supported by strips of adhesive plaster, and the intermediate space has been filled by granulation.

25th. There is firm union between the flaps by a narrow band with a notch below, and a small hole above. There is also a slight notch at the lower margin of the right ala nasi.

Sept. 9th. I performed another operation as follows. I made an incision along the base of the lower jaw, commencing at the median line, and extending to the right to a point about three cm. beyond a perpendicular line falling from the right angle of the mouth. The incision was then curved upward and backward to the horizontal level of the angle of the mouth, and thence upward and forward to the junction of the upper lip with the ala nasi, and thence forward along the upper margin of the lip into the vacant space which was left by the sloughing which followed the previous operation. This incision was extended deeply into the subcutaneous tissue along the base of the jaw, and when it passed through the cheek, it was extended through the mucous membrane into the buccal cavity. At the inner extremity of the large flaps included within the limits which have been described, a portion of the free margin of the right side of the lip was detached by an oblique incision from this isthmus, leaving a flap about twelve mm. in length, and five mm. in breadth at its right extremity and tapering to nothing at the left. A corresponding surface was prepared for the reception of this oblique flap, by dividing the left portion of the lip to a similar extent. The cicatricial tissue between the right and left portions of the lip was then dissected out. The right division of the lip, with the large curved flap to which it was attached, was then drawn to the median line, and attached by two pin sutures and a number of fine silk sutures, in such a position that the small oblique flap connected with the right segment of the lip overlapped the denuded portion of margin of the left segment, and was placed in accurate coaptation with it. In this way, the whole of the face margin of the lip was made continuous, without any appearance of a notch. After securing the lip in its place, the whole circumference of the flap was closely attached by sutures to the surrounding parts, without undue tension at any point. All the parts were then washed with carbolic acid lotion, one part to forty.

15th. Pins and sutures removed. Union throughout, except at two points, one a cm. from the columna, and a second smaller surface a little further to the right. The parts were supported by strips of adhesive plaster. The result of this operation was entirely successful, but when the parts were healed, there was a marked deficiency of the vermillion border of the right side of the upper lip, and a superfluity of the corresponding border of the lower lip.

On the 14th of October I operated, with the hope of remedying this condition.

A point was selected about seventeen mm. above the right angle of the mouth, and another point at the junction of the skin with the vermillion border of the lower lip, two cm. to the left of the right angle of the mouth. At each of these points a small pin was inserted through the skin, while a third point was selected in the cheek six mm. below a horizontal line extending back from the second point indicated and four cm. to the right of the angle of the mouth, and a third pin was inserted at that point. These pins were designed to mark the outlines of a triangular flap, whose base

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embraced the angle of the mouth, and whose apex corresponded with the point indicated by the third pin inserted into the cheek. Introducing the index finger of my left hand into the buccal cavity as a guide, I inserted the point of a Beer's cataract knife, at the point indicated by the first pin, into the cavity of the mouth, and made an incision to the point indicated by the third pin. I made another incision in the same manner from the third to the second pin, and thus separated the triangular flap from all its connections except around the angle of the mouth.

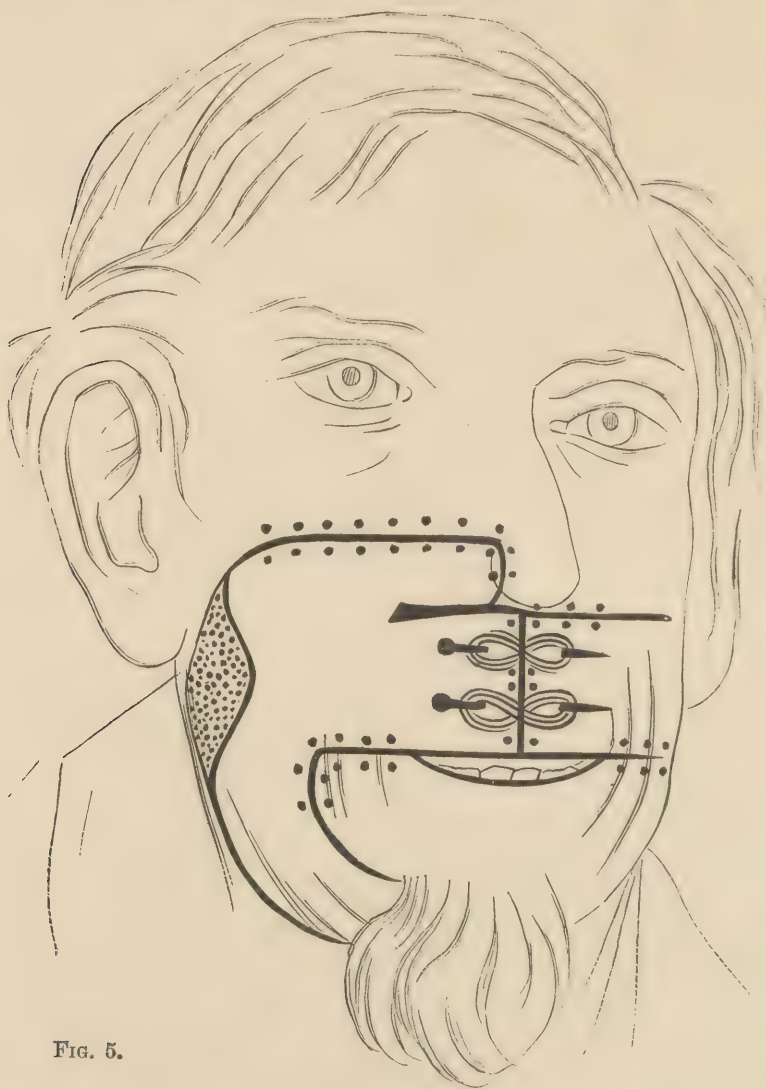


FIG. 5.

From the point indicated by the first pin, I made another incision vertically upward to an extent corresponding with the space between the first and third pins. This incision was carried to the periosteum, and from the tension of the parts involved, the edges receded so as to make a triangular chasm, adapted to the reception of the triangular flap. The flap was then turned edgewise until its apex was received into the apex of the triangular chasm, where it was firmly secured by a pin suture. The flap thus transplanted carried with it a considerable portion of the vermillion border of the lower lip, so as to bring it into line with the vermillion border of the upper lip. The flap was then secured by fine sutures to the edges of the triangular chasm, the outer line of the triangle being nearly vertical, while the inner line passed obliquely inward and downward toward the columna nasi. The edges of the chasm, from which the flap had been cut, were brought together with one pin suture and a num-

ber of fine silk sutures, the line of union extending from the outer side of the base of the flap in a direction downward and outward. When the wounds were all closed, it was found that the superfluity of the lower lip was entirely overcome, while there was ample material provided for the reconstruction of the upper lip. The flap which had been transplanted appeared more prominent than the surrounding parts, making the right side of the lip thicker than the left, which was the reverse of its previous condition.

ABSENCE OF THE UPPER LIP.

The pins were removed on the 15th and 16th, and the sutures on the 23d. The wound healed perfectly, leaving the right angle of the mouth elevated above its proper level to the extent of fifteen mm. The right cheek and the corresponding angle of the mouth were adherent to the maxillary bone.

On the 11th of November I endeavored to overcome these defects by the following operations. I divided the adhesions connecting the soft parts with the bone, and then cut a triangular flap with its apex above, and its base including the angle of the mouth, carrying the incisions into the buccal cavity, and drawing down the commissure of the lips until the angle of the flaps had descended about twelve mm. below the point from which it had been detached. This flap was fixed by sutures in its new position, and the sides of the space from which it had been taken were fixed in the same way. An incision was made above the portion of the vermilion border which had been raised from the lower lip, and a raw surface was made upon the corresponding edge of the upper lip to receive the flap thus raised, and this detached portion of vermilion border was then drawn across towards the median line, and secured by sutures in its new position. The position of the angle of the mouth was improved, but it was still above its proper level. To assist in bringing it down I cut another triangular flap below the angle of the mouth, its base including the commissure of the lips, and its apex extending toward the base of the lower jaw. Below the angle from which the apex had been cut, I made a straight incision downward to the extent of fifteen mm. and separated the sides of this incisions from each other, so as to form a new triangular flap. I then passed a loop of thread through the flap a little above its apex, and made traction so as to draw the apex of the flap down to the apex of the new triangular chasm. While this traction was made the flap was secured in its place by sutures, and the angle of the mouth was brought nearer to its proper position, but it still remained a little higher than that of the opposite side.

The sutures were removed on the 15th, and the wounds healed by first intention.

December 9th. The right angle of the mouth being considerably nearer to the median line than the left, I performed another operation for the purpose of extending the commissure outward and backward. To accomplish this object, I made an incision through the upper lip at the junction of the vermilion border with the skin, extending through the whole thickness of the lip into the buccal cavity, beginning about one cm. from the angle of the mouth, and carried around the angle along the lower lip, terminating at a distance of eighteen mm. from the commissure of the lips. I then made another incision commencing three mm. below the angle of the mouth, and extending fifteen mm. horizontally outward and backward through the whole thickness of the cheek, the anterior and internal extremity of this incision corresponding with the wound by which the vermilion border was detached from the cheek. A blunt hook was then introduced through a portion of the vermilion border detached from the lower lip, seven mm. on the inner side of what had previously constituted the angle of the mouth, and was drawn through the horizontal incision in the cheek, and the corresponding portion of the detached vermilion border was fixed in that position by a bead suture extending through the cheek eighteen mm. beyond the outer extremity of the wound. In this manner, the angle of the mouth was extended outward, and provided with vermilion border, mainly at the expense of the lower lip. The flap thus transplanted was secured in position by fine silk sutures.

23d. I made another effort to bring down the upper lip to its proper level. I made a horizontal incision immediately below the nose, extending on each side to a point vertically above the commissure



ILLUSTRATED MEDICINE AND SURGERY.

of the lips, and thence continued on each side downward and outward to the extent of six cm. beyond the angles of the mouth. These incisions were carried through into the buccal cavity, and the lip was brought down into its normal position. I then made an oblique incision through the lip, commencing at its upper part on the left side of the median line, and extending down to the vermilion border one cm. to the right of the median line, and the parts were then united by sutures, so that the relatively superfluous vermilion border of the left side overlapped the margin of the right side, a raw surface having been made for its reception. An attempt was then made to close the chasm made by the depression of the right side of the lip, by dissecting a flap from the upper part of the cheek, with a pedicle curved downward and outward to a point twelve mm. in front of the lobe of the ear. But when the flap was dissected from the subjacent parts, it was found that it could not be brought over to the internal limit of the chasm which it was designed to fill. In order to bring the flap into place, it was necessary to perform the hazardous experiment of dissecting the pedicle downward and inward to the base of the jaw, leaving the narrowest portion in front of the lobe of the ear only twelve mm. in breadth. The flap was then readily brought into place and secured by sutures, leaving a large chasm around the posterior circumference of the transplanted flap. The portion of the wound uncovered by integument was dressed with lint moistened with collodion. The surface of the flap was covered with lint smeared with salicylic ointment. 27th. The flap, which was at first pale, has assumed a brighter color. There is some œdematous swelling, with a burning sensation. The surface was washed with a carbolic acid lotion, one part to forty, and again dressed with salicylic ointment. 28th. A slight blush of erysipelas has appeared in the integument of the eyelids of the right side, and the flap has begun to assume a livid color. Ordered sulph. quiniæ, gr. viij., and tinct. ferri chloridi, min. x., to be given, and the inflamed integument to be penciled with tinct. iodini. 29th. The extremity of the flap, to the extent of five cm. has evidently lost its vitality. The erysipelas is spreading over the forehead, and has extended to the occiput. Jan. 5th, 1881. The space left by the separation of the slough is filling up with granulations. Feb. 11th. The contraction of the granulations, and the process of cicatrization, have gone on, until the chasm left by the separation of the sloughs has become nearly filled. March 4th. The wounds are substantially healed, and the right angle of the mouth has been drawn up nearly to the same position as before the last operation.

By my advice, the patient left the hospital, and went home to recruit his general health. I hope at some future time to make an effort to improve the position of the right oral commissure. The result of the first operation performed on this patient was very satisfactory, although it was far from restoring the perfect symmetry of the face. The subsequent operations contributed much less to the improvement of the patient's appearance than it was hoped that they would. The whole result has been the reconstruction of an upper lip which had been almost completely destroyed, the partial reparation of the notch in the right ala nasi, and the complete restoration of the columna nasi. The left side of the lip is nearly perfect, but the right side is drawn up above its proper level, and the mouth cannot be perfectly closed.

Note. This case was reported at the meeting of the American Medical Association held at Richmond, Va., May 4th, 1881, but has not been given to the public until the present time.

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